

McLaren Print System Order

Order No: 85611 Reprint Previous Order No: 6552
Order Date: 2024-05-20
User: Teresa Wenzlick
Phone: 9897795692

Ship Location: McLaren Comp and Readycare - Attn: Jenny
1523 S Mission St
Mt. Pleasant, MI 48858

Forms

Quantity: 500
Paragon Dept No: 55802
Dept Name: Teresa Wenzlick
Company Number: 810

Order Total Price: 16.75

Item Number: WC-117H
Item Description: Providers Report of Claim and Request for Medical Payment
Revision Date: 1/2012
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

PROVIDER'S REPORT OF CLAIM & REQUEST FOR MEDICAL PAYMENT
Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency

I. EMPLOYER TO COMPLETE THIS SECTION

Employer Name (Last, First, MI)		Employer Address
Employer Name		City/Town
State	Zip	Employer Telephone Number
Employer Name		Employer's Name
Employer Address		Employer Telephone Number
State	Zip	
Provide a brief description of the injury/illness.		
DATE OF INJURY	DATE OF REPORT	
Have you given leave to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there medical bills in your possession? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Signature	Employer Title	

Warning: Failure to furnish information to the purpose of obtaining or denying benefits may result in a criminal or civil prosecution, a civil and criminal penalty.

II. PROVIDER TO COMPLETE THIS SECTION

Health Care Provider Name		Provider Address
Address		City/Town
State	Zip	Employer's Representative/Insurance Carrier
Provider Signature		Employer's Representative/Insurance Carrier

This form is to be submitted to the workers' compensation insurance carrier, self-insured employer or group fund.
DO NOT MAIL THIS FORM TO THE WORKERS' COMPENSATION AGENCY